FINDLAY Women's Care
OBSTETRICS | GYNECOLOGY | MIDWIFERY

Financial Arrangements and Medical Insurance

Print Name:_____ DOB:_____

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help to you receive your maximum allowable benefits. We need your assistance and your understanding of our payment policy in order to achieve these goals.

Payment is due at the time the services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks and MC/Visa. We will be glad to process your insurance claim for you and any request must be accompanied by a copy of all current insurance cards. **IT IS YOUR RESPONSIBILITY TO OBTAIN PREAUTHORIZATION FROM YOUR INSURANCE COMPANY WHEN REQUIRED TO PROCESS AND PAY YOUR CLAIMS.** Most insurance policies require that individuals first meet a deductible and that a specific amount be paid by an individual before reimbursement is allowed. Please contact your insurance company prior to your first visit.

IN ORDER TO AVOID BILLING ERRORS, PLEASE PRESENT INSURANCE CARD WITH EACH VISIT.
Returned checks will be assessed an additional $27.00 charge. Balances over 90 days may be subject to additional collection fees and interest unless special arrangements are made with our accounting staff.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. We do realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions or uncertainty about the above information, **PLEASE** don't hesitate to ask us. We are here to help you.

I have read and understand the above Financial Policy and by my signature I acknowledge that payment of all services rendered is ultimately my responsibility. I acknowledge receipt of the "Financial Policy Pamphlet."

_____ / _____ / _____ / _____

Signature SS# DOB Today's Date

AUTHORIZATION AND ASSIGNMENT

I authorize the release of any medical or other information necessary to process my medical claims. I also authorize and request that payment of benefits be made directly to **FINDLAY WOMEN'S CARE**. I understand that this authorization will remain until I withdraw the authorization in writing.

_____ _____

Patient Signature Date

_____ _____

(Guardian Signature if patient is under 18) Address

PLEASE READ AND SIGN THE FOLLOWING: Thank you

Authorization for Treatment: I authorize Dr. Doty-Armstrong and their staff to provide routine examinations, diagnostic tests, procedures and treatments as deemed necessary. By signing, I give consent for the above and I understand that this consent will remain in effect until I withdraw it in writing.

_____ _____

Patient Signature Parent or Guardian Signature if Minor

_____

Date